

Managing the Low-Socioeconomic-Status Prostate Cancer Patient

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Management of patients with low socioeconomic status and/or low literacy who have prostate cancer presents a challenge to healthcare professionals. Improving treatment outcomes for these men requires specific educational programs to provide a better understanding of prostate cancer including careful posttreatment follow-up to ensure they have recovered well, that the cancer is not progressing and that complications are not proving troublesome. Practice nurses and health educators/navigators can play an important role in achieving these objectives. Education and knowledgeable advice can lead to earlier diagnosis of prostate cancer, improved patient participation in the treatment decision-making process and effective management of posttreatment complications.

Key words: prostate cancer ■ socioeconomic status ■ education ■ literacy

INTRODUCTION

Management of patients with prostate cancer may include “watchful waiting,” hormonal (androgen ablation) therapy, radical prostatectomy, cryosurgery, chemotherapy or radiation therapy in the form of external-beam radiotherapy, high-dose radiotherapy or brachytherapy. While clinical variables, such as age, disease stage, prostate-specific antigen (PSA) level, Gleason score, comorbidities and symptoms, are important considerations in the physicians’ selection of treatment(s),¹ patient participation in the decision-making process is desirable and generally encouraged. Therefore, provision of adequate information to patients is vital as they need to understand the benefits and risks of the treatment alternatives, the costs and follow-up procedures involved, and the likely survival and quality-of-life (QOL) outcomes.

Data to indicate a clear superiority of one treatment choice over another are, however, lacking,² and this uncertainty can affect the decision-making process—particularly when patients are faced with several options. In addition to clinical variables, numerous other factors may influence an individual patient’s decision concerning treatment, including income, insurance status, educational level, ethnicity, personality, lifestyle, philosophy/beliefs, previous life experiences and current health status. The interrelationships between these clinical and social variables can be very complex.³⁻⁶ An important consideration in patients’ participation in the decision-making process is how they access information and use it. This may not be fully appreciated by physicians, as information sources—ranging from the electronic media and specific literature to advice from friends—can vary widely in the way the benefits and risks of the various treatment options are portrayed.⁷ In addition, there may be limitations to physicians’ understanding of patient outcome preferences,⁸ which can adversely affect the patient-physician relationship.

Socioeconomic status, literacy and educational levels have important implications for patients’

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access to healthcare, ability to manage the bureaucracy of medical insurance and healthcare institutions, ability to attend clinics for follow-up visits, and their understanding of information provided to them on prostate cancer and its treatment.⁵ Lack of health insurance by many Americans is a major barrier to receipt of optimal healthcare; about 16% <65 years of age have no insurance coverage, while one-third of people ≥65 years of age have Medicare coverage only.⁹ In 2002, 18% of Americans aged 18–64 years reported having no regular source of healthcare, and for 6% cost had been a barrier to obtaining needed healthcare during the previous year.⁹ Percentages of the population among the various racial and ethnic groups of the U.S. population who have no healthcare coverage or no regular source of medical care are shown in Table 1 (American Cancer Society statistics).⁹

This article outlines the treatment options for patients with newly diagnosed prostate cancer and discusses how a low socioeconomic status and educational level can adversely influence therapeutic decision-making and, consequently, satisfaction with treatment outcomes. It also discusses measures designed to increase patients' informed participation in the shared decision-making process and to enhance their posttreatment QOL.

Treatment Options for Prostate Cancer: Current Trends in the United States

Management of prostate cancer is complex and subject to numerous clinical, scientific, demographic and economic dynamics, which give rise to constantly changing practices. Recent advances in therapy have reduced the incidence of some untoward effects, and patients can now be offered a range of treatments (Table 2) depending on their age, tumor stage (TNM classification; Table 3) and grade (Gleason score), and the presence or absence of comorbidities.¹¹ In the United States, guidelines developed by the National Comprehensive Cancer

Network (NCCN) provide recommendations for the appropriate use of both observation-only (appropriate for patients with a limited life expectancy or with low-risk cancers) and active interventions.¹ Following an initial assessment and staging evaluation, the NCCN guidelines advocate either “watchful waiting” (expectant management), radiotherapy, radical prostatectomy with or without lymph node dissection, hormonal therapy or combinations of these treatments depending on the patient's degree of risk and life expectancy. Whichever form of therapy is selected, patients should be monitored periodically via PSA tests, digital rectal examinations (DREs) and bone scans. In those who exhibit increasing PSA levels after prostatectomy, salvage therapy with radiation, chemohormonal therapy or hormonal therapy alone should be considered, while surgery (prostatectomy or cryosurgery) should be considered for those whose PSA levels rise after radiotherapy.^{1,11}

Increasingly, prostate cancer is being diagnosed with low-risk clinical characteristics, and the available evidence indicates a decrease in mortality with treatment of early-stage disease.^{16,17} Data from the Cancer of the Prostate Strategic Urologic Research (CaPSURE) program, which reflects a mix of locales and practice types, indicate that U.S. patients have become less likely to pursue “watchful waiting” in recent years and are more likely to receive brachytherapy or hormonal therapy.¹⁷ Since the advent of widespread PSA testing in the late 1980s, the percentage of low-risk patients being managed with “watchful waiting” has decreased by more than half, from 20% in 1993–1995 to 8% in 1999–2001. Over the same period, the use of both external beam radiotherapy and radical prostatectomy also decreased from 13% to 7% and 55% to 52%, respectively, while that of brachytherapy and primary hormonal therapy increased significantly from 4% to 22% and 7% to 12%, respectively.¹⁷ The explanation for these trends in primary management strategies is likely to involve a number of clinical, psychological,

Table 1. Socioeconomic characteristics and medical care access by race and ethnicity among the U.S. population (from American Cancer Society⁹)

Racial/Ethnic Group	Percentage of Individuals			
	Income below Poverty Level ^a	Graduated High School ^b	No Healthcare Coverage (<65 Years)	No Regular Source of Medical Care (<65 Years)
Whites (non-Hispanic)	8.0	85.5	11.9	13.9
African Americans	24.1	72.3	19.2	16.7
Hispanics/Latinos	21.8	52.4	34.8	30.8
American Indians and Alaskan natives	27.1	70.9	33.4	15.9
Asian Americans	10.1	80.4	17.1	18.5

a: 2002 poverty rates for whites (non-Hispanics), African Americans, Hispanics/Latinos and Asian Americans; and 1999–2000 poverty rate for American Indians and Alaskan natives (U.S. Census Bureau data); b: Educational attainment in 2000 (U.S. Census Bureau data)

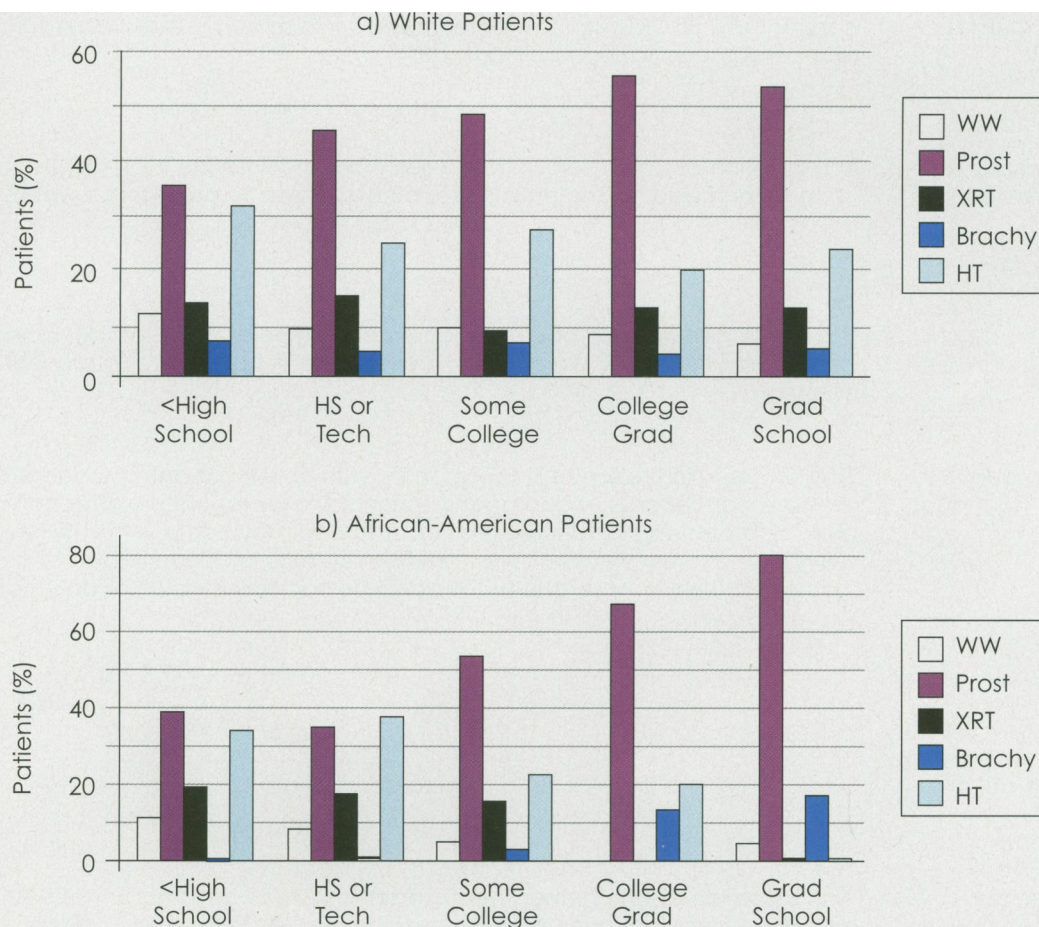
medicolegal and economic factors.

In this regard, changes in therapy costs and patients' expectations of the QOL benefits may be significant factors. Costs for individual patients include both the direct costs of treatment (including those arising from the management of posttreatment complications) and indirect costs such as travel to clinic appointments and missed workdays. The direct costs of initial therapy for localized prostate cancer are highly dependent on the treatment received, and they have been found to increase with higher-stage disease due to increased inpatient resource use and greater use of adjuvant hormonal therapy.¹⁸ However, initial treatment costs decrease with increasing age at diagnosis,^{13,19} probably reflecting greater use of "watchful waiting" in older men. Data from the CaPSURE database have indicated that first-year costs for treating prostate cancer in

the United States (based upon 1996 Medicare payment schedules) were \$6,810 for stage-T2c disease, \$6,426 for stage-T2a/b disease and \$5,731 for stage-T1c disease.¹⁸ Although first-year costs for radical prostatectomy and external-beam radiotherapy were similar (\$7,320 and \$7,430, respectively), they were considerably lower for patients followed with "watchful waiting" (\$484) and much higher for those who received neoadjuvant androgen ablation therapy followed by radical prostatectomy or radiotherapy (\$12,223).¹⁸

In addition to cost, projected QOL outcomes can also be an important treatment selection criterion in individual patients. QOL endpoints need to be assessed separately from clinical endpoints such as disease-free survival. Patients' perceptions of their posttreatment QOL—notably their urinary, bowel and sexual function after procedures such as radical

Figure 1. Treatment distribution according to educational level in: (a) 3,027 white men; and (b) 332 African-American men who were diagnosed with prostate cancer between 1992 and 2001



CaPSURE data (reproduced with permission from Kane et al.⁵; WW: "watchful waiting"; Prost: radical prostatectomy; XRT: external-beam radiotherapy; Brachy: brachytherapy; HT: hormonal therapy; HS: high school; Tech: technical school; Coll: college; Grad: graduate; Sch: school

prostatectomy, radiotherapy and androgen ablative therapy (Table 2)—may bias their viewpoint of the treatment options available to them in a different direction to that of the physician. Consequently, QOL dimensions such as functional status, sexuality, micturition, pain, fatigue, social activity and psy-

chological well-being—all of which can be measured via QOL instruments/questionnaires^{13,20}—need to be considered by physicians when discussing treatment options with patients, particularly as the patient may be less optimistic about the outcome than the physician suspects.^{4,21}

Table 2. Principal treatment options for patients with prostate cancer, indications, risks/untoward effects and

Treatment	Description
"Watchful waiting" (expectant therapy)	Careful observation and monitoring of patients via 6-month PSA tests and DREs and annual transrectal ultrasound-guided biopsy
Radical prostatectomy (with or without lymph node dissection)	Surgical removal of the prostate (plus some surrounding tissue) via a retropubic, perineal or laparoscopic approach. A nerve-sparing procedure may be feasible to help preserve erectile function
External-beam radiation therapy (EBRT)	Focused, high-energy rays or particles administered in fractionated doses to kill cancer cells. 3DCRT uses computer mapping to more precisely aim radiation and reduce damage to surrounding tissues
Brachytherapy (internal radiation therapy)	Implantation of small radioactive pellets ("seeds") into the prostate guided by imaging procedures. The pellets give off low doses of radiation for weeks or months
Cryosurgery (cryotherapy, cryoablation)	Liquid nitrogen freezing of cancer cells via insertion of metal probes guided by transrectal ultrasound. Warm saline is circulated in the urethra to prevent it from freezing
Androgen ablative therapy—hormonal	Ongoing administration of LHRH agonists, with or without antiandrogens, to deprive prostate cancer cells of androgens and inhibit their regulatory effect on cancer growth. (Note: an initial increase in testosterone may occur with LHRH therapy during the first few weeks of treatment, which may produce a flare of cancer symptoms; this response can be avoided by coadministration of antiandrogens ^c)
Androgen ablative therapy— orchiectomy	Surgical removal of testicles to reduce androgen production
Chemotherapy	Administration of chemotherapeutic agents such as doxorubicin, estramustine, etoposide, mitoxantrone, vinblastine, paclitaxel, docetaxel, carboplatin (often in combinations of two or more drugs ± prednisone) to kill cancer cells

a Relative to "watchful waiting". Costs include physician visits, DREs and PSA tests, biopsies, staging and follow-up costs, which are common to all conventional (external-beam) radiation therapy.¹⁴; c Combined androgen block (CAB) increases the cost of hormonal therapy.¹³; DRE: digital rectal

Influence of Socioeconomic Status, Literacy and Educational Levels on the Diagnosis and Treatment of Prostate Cancer

Although earlier studies (reviewed in Haas and Sakr²²) of the association between socioeconomic

status and prostate cancer incidence reported inconsistent findings, a more recent epidemiological study has suggested that the advent of widespread PSA testing in the United States has changed the relationship, due largely to the greater use of PSA screening among men of higher socioeconomic status.²³ Analysis of the relationship between socioeco-

relative costs^{1,10-14}

Recommended for	Risks/Untoward Effects	Relative Costs ^a
Older patients with a limited life expectancy; those in whom the cancer is not causing any symptoms, is small and is expected to grow slowly; those with significant comorbidities; and those who fear more aggressive therapies	Cancers commonly progress slowly but inexorably during long-term follow-up (active treatment may be needed in >50% of men within five years of diagnosis) ¹⁵	+
Localized cancers that have not spread outside the prostate gland	Surgical complications (eg, bleeding, blood clots, stroke, infection). Long-term urinary incontinence and erectile dysfunction (lower risk if nerve-sparing procedure able to be performed)	+++
Cancers confined within the prostate or that have only spread to nearby tissue. Also, cancers that have spread to a specific area of bone	Diarrhea (sometimes with proctitis giving rise to bleeding), rectal leakage, irritated colon; urinary incontinence (persistent in some cases); blood in urine, fatigue, late-appearing erectile dysfunction (~30% of patients within two years)	+++ ^b
Cancers confined within the prostate or that have only spread to nearby tissue	Urinary incontinence (may persist in one-third of patients); burning and rectal pain and/or diarrhea; erectile dysfunction (less likely than with external-beam radiation therapy)	++++
Localized prostate cancer (long-term effectiveness less well documented than with surgery or radiation therapy)	Erectile dysfunction (similar occurrence rate to radical prostatectomy); urinary frequency, pain/burning	++
Initial therapy in patients not able to receive surgery or radiation or in whom these therapies are unlikely to be effective (due to spread beyond prostate). After initial surgical or radiation therapy if cancer remains or recurs. Initial treatment prior to radiation therapy in patients at high risk of recurrences (neoadjuvant androgen ablative therapy)	Hot flashes (which may not subside over time); breast tenderness, gynecomastia; osteoporosis; anemia; loss of muscle mass; decreased mental acuity; weight gain; fatigue; loss of libido	++++ ^c
As for hormonal androgen ablative therapy (above)	As for hormonal androgen ablative therapy (above)	++
Cancer that has spread outside the prostate and is not controlled by hormonal therapy	Depending on drug given, dosage, and duration of treatment, untoward effects may include nausea and vomiting, hair loss, mouth ulcers, loss of appetite, low red or white blood cell counts, fatigue, increased risk of infections	+++

treatments. A requirement for hospitalization substantially increases the treatment cost, particularly if prolonged.^{13,14}; b 3DCRT increases the cost of examination; 3DCRT: three-dimensional conformal radiation therapy; LHRH: luteinizing hormone-releasing hormone; PSA: prostate-specific antigen

conomic status (defined by income and educational attainment) and prostate cancer incidence during the period 1972–1997 indicated no relationship in any racial or ethnic group prior to 1987; after this time, however, a strongly positive relationship was found for all racial/ethnic populations except Asians. Men of higher socioeconomic status were diagnosed with localized disease more frequently but with distant (metastatic) disease less frequently than men of low socioeconomic status.²³ Other studies have indicated that stage at diagnosis is inversely correlated with health insurance status among African Americans, in that only 50% of those with distant disease had health insurance as compared with 100% of those with localized disease,²⁴ and that men with Medicare only or no health insurance have a worse health-related QOL over time following treatment of prostate cancer than those with HMO insurance.²⁵

These findings suggest that men of lower socioeconomic status and with poorer health insurance coverage for prostate cancer screening services are diagnosed and treated later and, hence, have worse outcomes. However, where access to healthcare is equivalent among men of different socioeconomic status, as in the U.S. military, no association between socioeconomic status and either the stage of the disease at diagnosis or five-year survival is observed.²⁶

Low literacy may also be a significant barrier to the diagnosis of early-stage prostate cancer.²⁷ This has important influences on the complex interaction between patients and physicians and on patients'

understanding of the recommended treatments and, ultimately, their decision-making process.^{5,8} Data from the CaPSURE program have suggested that educational level is predictive of the primary treatment received by U.S. patients with newly diagnosed prostate cancer. Those with a lower educational level exhibited higher usage of primary hormonal therapy and decreased rates of radical prostatectomy compared with those who have a higher education level, and this was evident in both African Americans and whites (Figure 1).⁵ However, among older men (>75 years of age), those with higher educational levels received more radiotherapy and less primary hormonal therapy than those with lower educational levels, suggesting that the impact of education on primary treatment is different depending on patient age.

Other CaPSURE data have shown that among men for whom "watchful waiting" was the initial management, educational level was among the factors (others included age, PSA level and Gleason grade) predicting eventual active treatment. Men with a low educational level were less likely to receive active treatments than those with higher levels of education.²⁸ However, in predicting primary treatment, educational level appears to be less influential than clinical variables such as stage, grade and pretreatment symptoms. Clinical factors have such a strong influence on the physician's decision that the patient's educational level may become less important in determining what treatment is recommended and what the patient ultimately receives.⁵

Table 3. TNM (tumor, nodes, metastasis) classification of prostate cancer^{10,11}

Stage	Definition
T1	Tumor not palpable by DRE and not visible on imaging (e.g., TRUS)
T1a	Incidental tumor finding in ≤5% of prostate tissue removed on TURP for benign prostatic hypertrophy
T1b	Incidental tumor finding in >5% of prostate tissue removed on TURP for benign prostatic hypertrophy
T1c	Tumor identified by needle biopsy following an elevated PSA value
T2	Tumor confined within the prostate
T2a	Tumor involves one-half of one lobe of the prostate or less
T2b	Tumor involves more than one-half of one lobe (but not both lobes)
T2c	Tumor involves both lobes
T3	Tumor extends through the prostatic capsule
T3a	Unilateral or bilateral extracapsular tumor extension (but not to the seminal vesicles)
T3b	Tumor extends to the seminal vesicles
T4	Tumor is fixed or invades adjacent structures other than the seminal vesicles (e.g., bladder neck, external sphincter, rectum, levator muscles, pelvic wall)
NX	Lymph nodes not assessed
N0	No cancer spread to lymph nodes
N1	Cancer has spread to one or more regional lymph nodes
M0	No cancer spread beyond the regional nodes
M1	Distant metastases
M1a	Cancer has spread to distant lymph nodes
M1b	Cancer has spread to the bones
M1c	Cancer has spread to other sites, such as the lungs, liver or brain (with or without bone involvement)

DRE: digital rectal examination; PSA: prostate-specific antigen; TRUS: transrectal ultrasound; TURP: transurethral resection of the prostate

IMPROVING TREATMENT OUTCOMES IN PROSTATE CANCER PATIENTS WITH A LOW SOCIOECONOMIC STATUS: HOW CAN NURSES HELP?

Pretreatment Education and Counseling

As part of the counseling of men diagnosed with prostate cancer, healthcare practitioners (physicians, practice nurses and health educators/navigators) need to provide good information about the relative benefits and risks of the treatments advocated, including

their likely influence on subsequent QOL, and then incorporate patient preferences into the therapeutic decision.²⁹ In doing so, it should be appreciated that whereas some patients will want to maximize their chances for a “cure” and will accept the risk of post-treatment complications, such as urinary and sexual dysfunction, others will opt for a higher risk of prostate cancer recurrences to retain their present urinary and sexual function.³⁰ It also needs to be realized that patients may receive conflicting information about the benefits and risks of treatment from different sources and that there may be considerable uncertainty regarding cure rates, the likelihood of compli-

Table 4. Medical management of untoward effects commonly experienced by prostate cancer patients^{10,30,33,34}

Treatment	Untoward Effect	Management
Prostatectomy Radiotherapy (EBRT) Brachytherapy	Urinary incontinence (urge, stress, mixed urge/stress, overflow types)	<ul style="list-style-type: none"> • Incontinence pads/briefs • Exercises to strengthen bladder muscles (Kegel exercises) • Lifestyle changes (e.g., emptying bladder at bedtime or before strenuous activities; avoiding excessive drinking, particularly of caffeine-containing beverages or alcohol) • Self-catheterization • Penis compression devices • Anticholinergic drugs (e.g., oxybutynin, tolterodine) for urge incontinence • Collagen injections • Surgical procedures (e.g., artificial urinary sphincter, bulbourethral sling)
Radiotherapy (EBRT)	Diarrhea, enteritis	<ul style="list-style-type: none"> • Dietary modification (e.g., clear fluids/broths initially followed by soft foods as tolerated; small frequent meals; avoidance of fatty, fried or spicy foods) • Liberal fluid intake (avoidance of dehydration) • Antidiarrheal agents (e.g., kaolin/pectin, loperamide, diphenoxylate/atropine) • Anticholinergic/antispasmodic agents (e.g., propantheline, belladonna alkaloids) for abdominal cramping
Prostatectomy (non-nerve-sparing) Radiotherapy (EBRT) Brachytherapy Cryosurgery	Erectile dysfunction	<ul style="list-style-type: none"> • Phosphodiesterase-5 inhibitors (e.g., sildenafil, vardenafil, tadalafil) • Alprostadil (prostaglandin E1) injection, transurethral system • Vacuum devices • Penile implants
Hormonal therapy (LHRH agonists ± antiandrogens) Orchiectomy	Hot flashes	<ul style="list-style-type: none"> • Dietary/lifestyle changes (e.g., wearing loose-fitting cotton clothes; lowering room temperatures; stress reduction; exercise; limiting intake of spicy foods, caffeine, alcohol; sucking ice cubes) • Trial of progestins (e.g., megestrol acetate) or estrogens (e.g., transdermal estradiol) • Clonidine • Antidepressants (e.g., paroxetine, venlafaxine, fluvoxamine or sertraline) • Gabapentin • Acupuncture

EBRT: external-beam radiotherapy; LHRH: luteinizing hormone-releasing hormone.

cations occurring and the degree to which their lives will be affected by these complications.⁴ Although it might be assumed that a patient's treatment decision will be based on a rational assessment of the available information, this may not be the case as his interpretation of potential outcomes may be based on the personal context of a particular complication.⁶

While some patients may consider the information they receive from the physician during the critical "options talk" following the diagnosis of prostate cancer sufficient to make a decision, most will gather information from various sources ranging from books, pamphlets, friends and/or coworkers (influential others) and the Internet before either accepting or rejecting the physician's recommendation.⁶ Often, spouses or partners will be highly involved in the decision-making process, which emphasizes the importance of their inclusion in treatment-related discussions.⁴ Patients of low socioeconomic status with low literacy pose a particular problem for healthcare practitioners in this regard, as incomplete comprehension of the information they receive can prove a barrier to the shared decision-making process and, hence, in securing patient acceptance and satisfaction with the recommended treatment.

Thus, a challenge facing healthcare practitioners is to seek ways of enhancing patients' participation in this process, and this is especially relevant for those of low socioeconomic status and low literacy in view of the later diagnosis of prostate cancer, differing treatment patterns and worse outcomes in this population. Educational programs specifically tailored to this group need to be developed and incorporated into regular clinical practice to help these patients better understand prostate cancer and the benefits and risks of the treatments advocated, and as a result, improve levels of communication.⁸ Practice nurses and health educators/navigators can play an important role in developing and disseminating such programs and in providing support for patients and their families to allay fears and concerns about the diagnosis. As these issues may be difficult for some men to discuss and a low educational level may exacerbate this problem, help can be found from support groups^a and practitioners who are knowledgeable about prostate cancer.^{30,31}

As yet, no specific educational interventions have been proven to assist patients and their spouses or partners in the decision-making process, and precisely how nurses can best assist patients in this regard cannot be conclusively answered.⁴ Nevertheless, efforts to improve patients' knowledge and deal with preconceived biases that may influence the treatment decision seem likely to be beneficial.

Posttreatment Follow-Up

As well as pretreatment counseling and education, patients with prostate cancer require careful follow-up after treatment to ensure they have recovered well, are not experiencing a recurrence of the cancer, and not encountering any undue physical or psychological problems that diminish their QOL. Monitoring recommendations for ongoing PSA tests, DREs, bone scans and other investigations are beyond the scope of this review, but it is important to note that each therapeutic approach has its own requirements and potential complications. Practice nurses and health educators/navigators can play an important role in monitoring patients who are unable to attend specialist appointments (e.g., patients living in remote areas and those for whom inflexible work hours, familial demands, comorbid conditions or cost make travel prohibitive) and in providing psychosocial support for both patients and their families. The specialist physician will be responsible for ordering PSA and other laboratory tests, but the practice nurses and health educators/navigators can follow the results as well.³² As part of the follow-up assessment, application of a specific QOL instrument such as the FACT-G (Functional Assessment of Cancer Therapy—General scale) questionnaire, the Quality of Life Index and the EORTC (European Organization for Research and Treatment of Cancer) Quality of Life questionnaire—all of which are appropriate with interviewer assistance in patients of low socioeconomic status—may be useful to provide insight into patient functioning and to help discriminate between stable and progressive disease at the point of care.²⁰

Posttreatment complications that may be particularly troublesome for patients include urinary incontinence, radiation-induced diarrhea/enteritis, erectile dysfunction and, in those treated with androgen ablativ therapy, hot flashes. Patients should be comprehensively assessed for such problems and given the opportunity to discuss any difficulties they may be experiencing.³² Information on the many treatment options available to alleviate these complications should be provided (Table 4) and supportive management instituted whenever possible. Patients experiencing intractable symptoms should be assessed for their interest in a referral and encouraged to see a specialist physician about the problem.

CONCLUSIONS

As a consequence of their lower educational levels and economic circumstances, the diagnosis and treatment of prostate cancer in men of low socioeconomic status are generally later than for men of

^a For details, contact Cancer Care Inc., American Cancer Society, American Foundation for Urologic Disease, American Urologic Association, National Cancer Institute, Prostate Cancer Support Network, U.S. TOO Prostate Cancer Survivor.

higher socioeconomic status, and outcomes are consequently worse. In addition, low literacy often limits the ability of men of low socioeconomic status to comprehend information given to them about prostate cancer and its treatment, and this may adversely influence their ability to participate in shared decision-making regarding optimal treatment and, consequently, their satisfaction with the treatment they receive.

Barriers to delivering appropriate healthcare to men of low socioeconomic status include medical insurance and cost/copayment difficulties, language difficulties, homelessness, cultural attitudes and beliefs (e.g., healthcare may be perceived as a concern of females), concerns over sexuality, and reluctance to discuss or treat problems that involve the reproductive system. Improving the outcome for such men requires, initially, the implementation of educational programs tailored specifically to this population. The objective of such programs is to improve patient-physician communication; provide a better understanding of prostate cancer; and achieve higher levels of patient acceptance of the treatment(s) advocated on the basis of clinical variables such as age, stage, PSA level, Gleason score and comorbidities. The better informed patients are, the more assertive they are likely to be in seeking interventions that will provide the optimal result for their particular situation, i.e., the desired balance between the chance of a "cure" on the one hand and possible occurrence of unacceptable posttreatment complications on the other.

Improving outcomes also requires careful post-treatment follow-up to ensure that patients are following instructions on recovery activity levels, changes of dressings and fluid intake; are not experiencing a cancer recurrence; and are not unduly bothered by complications such as urinary incontinence, erectile dysfunction, postradiation diarrhea/enteritis, or hot flashes. Patients should be given the opportunity to discuss difficulties they are experiencing because self-image concerns and cultural barriers to effective dialogue may lead to problems being ignored and having an adverse influence on QOL. Active questioning of patients about likely posttreatment complications and the application of specific QOL instruments may be useful to gain insights into patient functioning and to effectively identify problems early.

In summary, practice nurses and health educators/navigators can play an important role in implementing educational strategies designed to improve knowledge about prostate cancer and its treatment, monitoring patients posttreatment (particularly when their ability to attend specialist follow-up appointments is compromised), advising on management of posttreatment complications and providing psychoso-

cial support for patients and their families. In doing so, nurses need to be aware of the issues and controversies surrounding the screening for and early detection of prostate cancer, and the benefits and risks of the treatment options available. For patients of low socioeconomic status, education and well-informed advice have the potential to result in: 1) improved detection of prostate cancer such that it is diagnosed at an earlier stage and the incidence of metastatic disease is decreased, 2) improved dialogue with the physician such that patient participation in the treatment decision-making process is enhanced, and 3) improved detection and management of posttreatment complications such that QOL is maximized.

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